STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155005	A. BUILDING 00 B. WING	05/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	1345 N MADISON AVE ANDERSON, IN46011

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F0000	This visit was for the Investigation of Complaint IN00090572. Complaint IN00090572- Substantiated, federal/state deficiencies related to the allegations are cited at F279 and F328. Survey dates: May 18, 19, 2011 Facility number: 000005 Provider number: 155005 AIM number: 100270840 Surveyor: Jeri Curtis, RN Census bed type: SNF: 27 SNF/NF: 116 Total: 143 Census payor type: Medicare: 27 Medicaid: 87 Other: 29 Total: 143 Sample: 5 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0279 SS=D	Quality review completed on May 23, 2011 by Bev Faulkner, RN A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review, and interview, the facility failed to develop a plan of care to meet the immediate assessed care, suctioning, and respiratory, needs of 1 (Resident A) of 4 residents, among the sample of 5, reviewed for tracheostomy care. Findings include: The record of Resident (A) was reviewed at 3:15 P.M., 5/18/11, and indicated a 4/29/11, admission with diagnoses including, but not limited to, status post respiratory arrest with a trach	F0279	Resident A no longer resides at the facility.Residents with trachs are like residents.Licensed nursing staff will be educated on the guideline for completion of a comprehensive care plan.Admission charts will be audited within 48 hours of admission by the Interdisciplinary Team or designee to ensure care plans have been developed to address immediate needs identified upon admission.Changes in condition or orders that require care plan updates will be reviewed through the Eagle Room process.The Administrative Director of Nursing Services or designee will review 3	06/13/2011

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	(tracheostomy), cardiovascular disease, and hypertension. The initial 4/29/11, physician orders was suctioning as necessary with trach care every shift and when needed. The orders were changed on 5/3/11, to suction and lavage of the trach every 4 hours and as needed. The 5/3-5/6/11, treatment administration record (TARS) indicated the suctioning and lavage were completed every 4 hours through 6:00 A.M., 5/6/11. Documentation did not indicate the 5/6/11, 10:00 A.M., suctioning of the trach was done. At 3:50 P.M., 5/19/11, the 4/29-5/6/11, record of Resident (A) was reviewed with the Director of Nursing (DoN). Documentation did not indicate a plan of care for trach care and suctioning. The DoN indicated facility policy required an initial plan of care to meet all immediate needs. At 4:45 P.M., 5/19/11, the Administrator provided the facility's 9/10, Care Area Assessment and Care Plan Completion Policy. The purpose was federal regulation requirements to conduct initial and periodic assessments of all residents. The assessment information was to be used to develop, review, and revise the plan of		admission chart audits weekly times 6 weeks to ensure completion of care plans. Any concerns identified will be addressed and findings submitted to the QA&A committee weekly. **Addendum Response** **What is the "Eagle Room" process?** The Eagle Room process is an on-going, interdisciplinary, care and service management system. The attendees serve as a subcommittee of the Quality Assessment and Assurance (QAA) Committee.**How will the facility ensure residents requiring tracheostomy suctioning receive this care timely?** Treatment Administration Records will be audited by the Administrative Director of Nursing Services or designee for all residents receiving tracheostomy suctioning care 5 times per week for 4 weeks and then as determined by the QA & A committee. **If the monitoring of this plan of correction is less than six months, how will the facility ensure the plan remains in place?**	

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	care to provide services to attain or maintain the resident's highest practicable physical needs. Point #4 indicated it was important to note for an admission assessment, the resident had entered the facility with a set of physician based orders. Staff were to review these orders and begin to assess the resident and identify potential care issues/problems. In many instances interventions would have been implemented to address priority issues prior to the completion of the final care plan. At that time, many of the resident's problems would have been identified, causes considered, and a preliminary care plan initiated. This federal tag relates to Complaint IN00090572. 3.1-35(a) 3.1-35(b)(1)		Monitoring of this plan of correction will be ongoing for a minimum of six months. **What is the criteria to discontinue monitoring?** Compliance with this plan of correction will be monitored by our QA & A committee. Information gathered from the audits will be forwarded to the QA&A committee for review during the monthly meeting. Upon review, the QA&A committee will make further recommendations. This process will continue until the process is deemed stable by the QA&A committee.	
F0328 SS=G	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on record review and interview, the	F0328	Resident A no longer resides at	06/13/2011

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	facility failed to ensure tracheostomy suctioning every 4 hours as ordered by the physician to maintain an airway, which resulted in respiratory distress, unresponsiveness, and cardiac arrest requiring resuscitation and hospitalization for 1 (Resident A) of 4 residents among the sample of 5, reviewed for tracheostomy care. Findings include: The facility's 1/11, Respiratory: Suctioning-Nasal, Oropharyngeal and Tracheostormy Policy was provided by the Director of Nursing 5/18/11. The purpose was to remove secretions from the pharynx, trachea and bronchi, to maintain a patent airway, decrease the potential for infection, and stimulate the cough reflex. Family member #1 of Resident (A) was interviewed by telephone at 1:45 p.m., 5/18/11. Family member #1 indicated on 5/6/11, following the respiratory distress and cardiac arrest,the emergency room (ER) physician had said a lack of oxygen over several minutes had led to a cerebral vascular accident (CVA, or stroke) causing brain damage. Family member #1 indicated the ER physician had explained a new tracheostomy (trach) required suctioning		the facility.Residents with trachs are like residents.Licensed nursing staff will be educated on documentation of treatments on the Treatment Administration Record and required documentation or notification if resident refuses care or treatment. An audit of the identified residents Treatment Administration Record will be completed by the ADNS or designee to ensure appropriate documentation in place. Treatment Administration Record audits of like residents will be done 3 times weekly, concerns will be addressed and findings of audit submitted to the QA&A committee for review. **Addendum Response** **What is the "Eagle Room" process?** The Eagle Room process is an on-going, interdisciplinary, care and service management system. The attendees serve as a subcommittee of the Quality Assessment and Assurance (QAA) Committee.**How will the facility ensure residents requiring tracheostomy suctioning receive this care timely?** Treatment Administration Records will be audited by the Administrative Director of	

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	more than 3-4 times a day, and if not done, would result in aspiration. Family member #1 indicated the ER physician had also said the trach was clogged with thick secretions, with no place to go, and had shut off the air way of Resident (A). The record of Resident (A) was reviewed at 3:15 P.M., 5/18/11, and indicated a 4/29/11, admission with diagnoses including, but not limited to, status post respiratory arrest with a trach, cardiovascular disease, and hypertension. The initial 4/29/11, physician orders was suctioning as necessary with trach care every shift and when needed. The orders were changed on 5/3/11, to suction and lavage of the trach every 4 hours and as needed. The 5/3-5/6/11, treatment administration record (TARS) indicated the suctioning and lavage were completed every 4 hours through 6:00 A.M., 5/6/11. Documentation did not indicate the 5/6/11, 10:00 A.M., suctioning of the trach was done. A 5/6/11, 12:35 P.M., nursing note, documented by Licensed Practical Nurse (LPN #1) indicated Resident (A) was being changed by staff and began having a, "panic attack." Documentation indicated trach care was performed. .LPN		Nursing Services or designee for all residents receiving tracheostomy suctioning care 5 times per week for 4 weeks and then as determined by the QA & A committee. **If the monitoring of this plan of correction is less than six months, how will the facility ensure the plan remains in place?** Monitoring of this plan of correction will be ongoing for a minimum of six months. **What is the criteria to discontinue monitoring?** Compliance with this plan of correction will be monitored by our QA & A committee. Information gathered from the audits will be forwarded to the QA&A committee for review during the monthly meeting. Upon review, the QA&A committee will make further recommendations. This process will continue until the process is deemed stable by the QA&A committee.	

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	#1 documented she was unable to suction the trach. Documentation indicated the nurse practitioner (NP #1) was called to the room and lavaged the resident. Resident (A) became unresponsive, compressions were started, and 911 was called. Resident (A) was transported to the hospital by the emergency medical service (EMS). At 1:40 P.M., 5/19/11, a visit was made to the hospital. The Registered Nurse (RN) Medical Unit Manager (#1) indicated Resident (A) had been transferred to her unit from intensive care following a cardiac arrest. RN Unit Manager (#1) indicated family member #1 had requested Resident (A) not return to the facility due to concerns with the trach care. The review of the 5/6/11, hospital record included the EMS 12:30 P.M.,record with documentation the nursing staff had initiated cardio pulmonary resuscitation (CPR) prior to their arrival. The EMS noted a radial pulse. An electro cardiogram (ECG) monitor was placed and indicated a sinus tachycardia (rapid rate). The EMS documented when in Medic 2 during transport, the crew suctioned the trach and an occlusion was removed.			

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The 5/6/11, ER report indicated respiratory and cardiac arrest on arrival with oxygen saturation levels in the 50s. Documentation indicated when a trach replacement was attempted, Resident (A) again had cardiac arrest and CPR was given.
Documentation indicated after the trach was changed to a #7 endo-tube, Resident (A) immediately had good breath sounds and the oxygen saturation increased to 96%. The ER physician documented the trachea had a large mucous plug distally. The physician also documented the trach cuff had been defective when Resident (A) had been seen in the ER on 5/3/11, and was not inflatable.
The primary diagnosis was respiratory failure. An additional diagnosis was blocked trachea secondary to mucous plug with cardio pulmonary arrest.

LPN #1 was interviewed by telephone at 3:55 P.M., 5/19/11. LPN #1 indicated Resident (A) had gestured she did not want trach care at 10:00 A.M., 5/6/11. LPN #1 indicated Resident (A) was not congested and there was no respiratory trouble at the time. LPN #1 indicated she had honored the preference of Resident (A) and had omitted the suctioning.

The DoN was interviewed at 4:30 P.M.,

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	5/19/11. The DoN indicated honoring a resident's choice for refusal of suctioning would be permissible if there were no secretions or respiratory problems. The DoN indicated protocol would be to re-approach the resident within an hour after the refusal, assess, and re-attempt to suction the trach. This federal tag relates to Complaint IN00090572. 3.1-47(a)(5)			